

State of Rhode Island - Division of Motor Vehicles
Motor Vehicle Accident Report

FOR DMV USE ONLY

CASE NO.

IMPORTANT NOTICE

If your accident involved an **UNINSURED MOTORIST**, please include with your report an itemized estimate of damage to your vehicle and/or property and any medical bills and/or lost wages. **DO NOT SUBMIT AN ITEMIZED ESTIMATE if all vehicles involved in the accident are insured.** (read below for more information)

If you were directly or indirectly involved in a motor vehicle accident, you must submit one or more of the following (if applicable) pursuant to R.I.G.L. § 31-31 "Safety Responsibility Administration - Security Following Accident":

If there was **damage to your vehicle** and the amount of damage is in excess of \$1000.00 you must provide any and all documents to this department (i.e. itemized estimates of repair, completed and signed by the repair shop and/or a letter from an insurance company, if vehicle was totaled). Please make sure that the repair estimate includes make, model and year of the vehicle, as well as the VIN. Also include the date and location of the accident.

If there was **damage to your property** (non-vehicle) and the amount of damage is in excess of \$1000.00 you must provide any and all documents to this department (i.e. itemized estimates of repair, including materials and labor; copy of all receipts for expenses incurred to repair property damaged, and any other documents you feel are necessary). Also include the date and location of the accident (address), and include the type of property damaged (i.e. mailbox, fence, building, etc).

If you, as an operator, passenger or pedestrian, incurred medical expenses as a result of an injury stemming from an accident please provide an **attending physician report** detailing the description of injuries, probable period of disability, whether or not hospitalization was needed and the total estimated expenses, including fees. The Division of Motor Vehicles Office of Safety Responsibility also will accept alternative rehabilitative statements/bills (i.e. physical therapy).

In addition to providing an attending physician report, if you have experienced the loss of wages as a result of a motor vehicle accident you must provide verification of loss of wages from your employer which details number of hours missed, hourly rate or salary, and a calculated estimate of wages lost per time period stated. The report from your employer should contain the following information: Name, address, gender, age and occupation of injured and the employer's name, title, address, contact phone number and signature. **The Division of Motor Vehicles Office of Safety Responsibility will not accept this form unless it is also signed by the injured party.**

MOTOR VEHICLE ACCIDENT REPORT -- INSTRUCTIONS

Instructions for completing the accident report:

1. Print in all areas required, except for signatures.
2. Answer all questions to the best of your knowledge. Give facts only. Do not guess or assume.
3. When multiple choices are provided, select the best choice.
4. When reporting, enter YOUR information under "YOUR VEHICLE" and the other driver's information under "OTHER VEHICLE."
5. If more than two (2) vehicles were involved, more than two (2) persons were injured or property belonging to more than one person was damaged, use an additional accident report to complete the appropriate sections.
6. Print one letter per box. Leave a blank in one box between each word. Do not use periods of commas.
7. Please remember to **SIGN** the accident report.
8. IF YOU ARE MAILING IN YOUR REPORT: Make sure the report is securely sealed in an envelope and mail it to the RI DMV Safety Responsibility Office at 600 New London Avenue, Cranston, RI 02920-3024.

| | | | | | | | | |
|--|--|--|--|--|--|---|--|--|
| LOCATION AND TIME | MONTH <input type="text"/> <input type="text"/> DAY <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> | DAY OF WEEK <input type="checkbox"/> MONDAY <input type="checkbox"/> THURSDAY <input type="checkbox"/> SUNDAY <input type="checkbox"/> TUESDAY <input type="checkbox"/> FRIDAY <input type="checkbox"/> WEDNESDAY <input type="checkbox"/> SATURDAY | HOURL <input type="text"/> <input type="text"/> MIN <input type="text"/> <input type="text"/> | AM <input type="checkbox"/> PM <input type="checkbox"/> | TOTAL VEHICLES INVOLVED <input type="text"/> | TOTAL INJURED INVOLVED <input type="text"/> | TOTAL PEDESTRIANS INVOLVED <input type="text"/> | |
| | ACCIDENT OCCURRED ON (PRINT NAME OF STREET OR HIGHWAY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | IF NOT AN INTERSECTION | | | |
| | ACCIDENT OCCURRED IN (NAME OF CITY OR TOWN) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | | | | |
| IF AT INTERSECTION (NAME OF INTERSECTING STREET OR HIGHWAY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | HOW MANY FEET FROM NEAREST INTERSECTION ? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | |
| | | | | IN WHAT DIRECTION ? <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W FROM | | | | |
| | | | | NAME NEAREST INTERSECTING STREET OR HIGHWAY <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | |
| YOUR VEHICLE | OPERATOR'S NAME (FIRST, MIDDLE, LAST) <input type="text"/> <input type="text"/> <input type="text"/> | | DATE OF BIRTH MO <input type="text"/> <input type="text"/> DAY <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> | SEX M <input type="checkbox"/> F <input type="checkbox"/> | OPERATOR'S LICENSE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | STATE <input type="text"/> | DIRECTION OF TRAVEL <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W |
| | RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | VEHICLE PLATE NUMBER AND STATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | TELEPHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | |
| | VEHICLE OWNER (COMPLETE NAME & ADDRESS) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | OWNER'S LICENSE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | VEHICLE IDENTIFICATION NUMBER (VIN) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | |
| | OWNER'S DATE OF BIRTH MO <input type="text"/> <input type="text"/> DAY <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> | VEHICLE MAKE <input type="text"/> | VEHICLE MODEL <input type="text"/> | YEAR <input type="text"/> | REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.) <input type="text"/> | | TELEPHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | |
| OTHER VEHICLE | OPERATOR'S NAME (FIRST, MIDDLE, LAST) <input type="text"/> <input type="text"/> <input type="text"/> | | DATE OF BIRTH MO <input type="text"/> <input type="text"/> DAY <input type="text"/> <input type="text"/> YEAR <input type="text"/> <input type="text"/> | SEX M <input type="checkbox"/> F <input type="checkbox"/> | OPERATOR'S LICENSE NUMBER <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | STATE <input type="text"/> | DIRECTION OF TRAVEL <input type="checkbox"/> N <input type="checkbox"/> S <input type="checkbox"/> E <input type="checkbox"/> W |
| | RESIDENCE ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | VEHICLE PLATE NUMBER AND STATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | TELEPHONE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | |
| | VEHICLE OWNER (COMPLETE NAME & ADDRESS - LINE 1) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | VEHICLE IDENTIFICATION NUMBER (VIN) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | | | |
| | (NAME & ADDRESS - LINE 2, IF NEEDED) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | VEHICLE MAKE <input type="text"/> | VEHICLE MODEL <input type="text"/> | YEAR <input type="text"/> | REGISTRATION CLASSIFICATION (PASSENGER, COMMERCIAL, MOTORCYCLE, CAMPER, ETC.) <input type="text"/> | | |

AFTER FILLING OUT YOUR MOTOR VEHICLE INSURANCE INFORMATION BELOW, TURN OVER AND CONTINUE THE APPLICATION ON THE OTHER SIDE



DO NOT DETACH - THIS SECTION NEEDS TO REMAIN WITH THE ACCIDENT REPORT

| YOUR MOTOR VEHICLE INSURANCE INFORMATION | | |
|---|---|---|
| DATE OF ACCIDENT: <input type="text"/> | PLACE OF ACCIDENT: <input type="text"/> | FOR DMV USE ONLY CASE NO. <input type="text"/> |
| DESCRIPTION OF VEHICLE INVOLVED IN ACCIDENT MUST CORRESPOND TO "YOUR VEHICLE" ON ACCIDENT REPORT | | |
| VEHICLE MAKE: <input type="text"/> | TYPE: <input type="text"/> | YEAR: <input type="text"/> VIN: <input type="text"/> |
| NAME OF OPERATOR: <input type="text"/> | STREET ADDRESS: <input type="text"/> | CITY / TOWN: <input type="text"/> STATE / ZIP: <input type="text"/> |
| NAME OF OWNER: <input type="text"/> | STREET ADDRESS: <input type="text"/> | CITY / TOWN: <input type="text"/> STATE / ZIP: <input type="text"/> |
| NAME OF INSURANCE COMPANY (NOT AGENT): <input type="text"/> | POLICY NUMBER: <input type="text"/> | EFFECTIVE PERIOD: FROM: <input type="text"/> TO: <input type="text"/> |
| NAME OF POLICYHOLDER: <input type="text"/> | STREET ADDRESS: <input type="text"/> | CITY / TOWN: <input type="text"/> STATE / ZIP: <input type="text"/> |
| NAME OF INSURANCE AGENT WHO ISSUED POLICY: <input type="text"/> | STREET ADDRESS: <input type="text"/> | CITY / TOWN: <input type="text"/> STATE / ZIP: <input type="text"/> |
| YOUR SIGNATURE: <input type="text"/> | DATE SIGNED: <input type="text"/> | |

| NON-VEHICLE PROPERTY DAMAGE | | | |
|---|--|---|---|
| <input type="checkbox"/> STATE PROPERTY | | <input type="checkbox"/> CITY/TOWN PROPERTY | |
| <input type="checkbox"/> PRIVATE PROPERTY | | | |
| OWNER'S NAME | | OWNER'S ADDRESS (NUMBER & STREET, CITY OR TOWN, STATE & ZIP CODE) | |
| HOME PHONE | CELL PHONE | WORK PHONE | DAMAGE DESCRIPTION |
| VEHICLE DAMAGE | | APPROXIMATE COST TO REPAIR YOUR VEHICLE (VEHICLE 1) \$ _____ | APPROXIMATE COST TO REPAIR OTHER VEHICLE (VEHICLE 2) \$ _____ |
| INJURED | NAME OF INJURED (FIRST, MIDDLE INITIAL, LAST) _____ CITY/TOWN _____ | | INJURED WAS RIDING IN VEHICLE # <input type="checkbox"/> |
| | AGE <input type="text"/> <input type="text"/> SEX M <input type="checkbox"/> F <input type="checkbox"/> | ACCIDENT SEVERITY CONDITION AT SCENE OF ACCIDENT | |
| | 1 <input type="checkbox"/> FATAL | 3 <input type="checkbox"/> BRUISES OR ABRASIONS | 1 <input type="checkbox"/> PEDESTRIAN |
| | 2 <input type="checkbox"/> BLEEDING OR BROKEN BONES | 4 <input type="checkbox"/> COMPLAINT OF PAIN | 2 <input type="checkbox"/> PEDALCYCLIST |
| | | 3 <input type="checkbox"/> PASSENGER IN BUS | 5 <input type="checkbox"/> VEHICLE OPERATOR |
| | | 4 <input type="checkbox"/> OTHER | 6 <input type="checkbox"/> VEHICLE PASSENGER |
| | | | 7 <input type="checkbox"/> MOTORCYCLE OPERATOR |
| | | | 8 <input type="checkbox"/> MOTORCYCLE PASSENGER |
| NAME OF INJURED (FIRST, MIDDLE INITIAL, LAST) _____ CITY/TOWN _____ | | STATE/ZIP _____ | INJURED WAS RIDING IN VEHICLE # <input type="checkbox"/> |
| ACCIDENT CONDITIONS | ACCIDENT INVOLVED COLLISION WITH ... | | |
| | 1 <input type="checkbox"/> PEDESTRIAN | 4 <input type="checkbox"/> MOVING VEHICLE | 7 <input type="checkbox"/> FIXED OBJECT |
| | 2 <input type="checkbox"/> PEDALCYCLE | 5 <input type="checkbox"/> VEHICLE STOPPED IN ROAD | 8 <input type="checkbox"/> OBJECT IN ROAD |
| | 3 <input type="checkbox"/> NO COLLISION - RAN OFF ROAD | 6 <input type="checkbox"/> PARKED MOTOR VEHICLE | 9 <input type="checkbox"/> NO COLLISION - OVERTURNED |
| | | 10 <input type="checkbox"/> OTHER _____ | |
| IN YOUR OWN WORDS, PLEASE DESCRIBE WHAT HAPPENED ... | | | |
| | | | |
| I, THE UNDERSIGNED, DECLARE UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE ON THIS REPORT ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. | | | |
| OPERATOR'S SIGNATURE (THIS REPORT MUST BE SIGNED): _____ | | PRINT YOUR NAME: _____ | DATE: _____ |
| YOUR INSURANCE INFORMATION | WAS YOUR VEHICLE OR THE VEHICLE YOU WERE OPERATING INSURED (LIABILITY INSURANCE) AT THE TIME OF THE ACCIDENT? IF "YES", COMPLETE ATTACHED FORM <input type="checkbox"/> YES <input type="checkbox"/> NO | NAME OF YOUR INSURANCE COMPANY (NOT AGENT) _____ | POLICY NUMBER _____ |
| | | NAME OF POLICYHOLDER _____ | POLICY EFFECTIVE DATES FROM: _____ TO: _____ |
| | | STREET ADDRESS _____ | CITY/TOWN _____ |

DO NOT DETACH – THIS SECTION NEEDS TO REMAIN WITH THE ACCIDENT REPORT

| FOR USE BY INSURANCE COMPANY ONLY - DO NOT WRITE IN THIS AREA | |
|--|--|
| RETURN THIS FORM ONLY IF <u>NO STANDARD POLICY WAS IN EFFECT AS ALLEGED BY MOTORIST</u> WITH REGARD TO AN AUTOMOBILE LIABILITY INSURANCE POLICY FOR THE POLICYHOLDER NAMED ON THE REVERSE SIDE HEREOF, THE UNDERSIGNED INSURANCE COMPANY ADVISED YOU IN ACCORDANCE WITH THE ITEMS CHECKED BELOW: | |
| 1 <input type="checkbox"/> No policy was in effect on the date of the accident. | |
| 2 <input type="checkbox"/> Our policy for the named policyholder applies to him/her as the operator but it does not apply to the owner of the vehicle involved in the accident. | |
| 3 <input type="checkbox"/> Our policy applies to the owner of the vehicle, but does not apply to the operator of the vehicle involved in the accident. | |
| 4 <input type="checkbox"/> Our policy affords bodily injury coverage only. | |
| 5 <input type="checkbox"/> Our policy affords property damage coverage only. | |
| Remarks: _____ | |
| [To: STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS] DIVISION OF MOTOR VEHICLES 600 NEW LONDON AVENUE CRANSTON, RI 02920-3024 | |
| DATE: _____ | _____ Name of Insurance Company |
| | By: _____ Authorized Representative |